productive environment? If I interpret correctly the success of bumper stickers, reiterating every day their silent messages of likes and loves through the long hours of commute, I shall argue that people do miss the opportunity to talk about themselves. But there is no time, not for talking, not for listening. One then wonders how fulfullingly is our time otherwise spent, for what ultimate goal are we striving and competing. Is the goal to enhance the quality of life? How can we achieve it if we ignore each other's unique needs and hopes? These questions are relevant to our global social demeanor, as they are to our practice of medicine. Diagnosing and treating are restrictive technical synonyms for understanding and healing, whose chances to occur depend upon the full availability of the parties involved. One cannot heal unless one understands, and one cannot understand unless one explores. Nor can one be healed without being understood and, in order to be understood, one must find or be given the opportunity to recount one's self. Reciprocal comprehension and trust are engendered through friendly, unhurried conversations much more than through form-guided anamneses that have little subtlety for matters of the soul.

The problem may be that we are not taught much of the art of conversing. Watching television, playing computer games, technical reading and multiple-choice exams add very little to our dialectic capabilities. But if conversation glows in the artist, it thrives in the amateur. And amateur we can easily become by starting to cultivate the pleasure of discovering our neighbor, our relative, our patient. The first attempts at an unpracticed activity may be clumsy, even embarrassing, but after a while craftmanship develops: the attitude, the tone of voice, the words almost elect themselves from among the many possible, and self-perpetuating ties are established. We should not miss such simple opportunities to add genuineness to the practice of medicine and benevolence to life around us.

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Immune Complex Disease—Adult Still's Disease? Hepatitis B?

TO THE EDITOR: We have recently seen a patient with clinical and laboratory features consistent with adult Still's disease. Results of serologic testing during the course of illness, however, have raised a conundrum that we feel merits emphasis. We hope this case report will be a valuable addition to Dr Larson's review in the May issue.[1]

Report of a Case

A 29-year-old previously healthy man presented with a four-day history of fever, pharyngitis, polyarthralgias and myalgias. He appeared acutely ill with a temperature, taken orally, of 39.9°C. A maculopapular rash was seen on the anterior thorax and proximal upper extremities. Bilateral synovitis of knees and elbows and hepatomegaly with scleral icterus were present. Initial laboratory tests showed anemia, leukocytosis, elevated liver function values, proteinuria and cylindruria. Antistreptolysin O, rheumatoid factor, antinuclear antibodies, cryoglobulins, complement profiles and multiple serologic tests were negative. Tests for hepatitis B surface antigen (HB_sAg) and anti-HB_sAg were negative. All cultures showed no growth. Subsequently, pleuropericarditis with bibasilar rales, pedal edema, an S3 and a three-component rub developed. Splenomegaly was noted. Pharyngitis and rash were evanescent. An x-ray study of the chest showed a left lower lobe infiltrate with effusion and cardiomegaly. An echocardiogram confirmed a pericardial effusion. A 24-hour collection of urine showed 3.2 grams of protein. Open lung, kidney and bone marrow biopsies were carried out and findings were all nondiagnostic. The patient improved with corticosteroids. Repeat anti-HB_sAg and anti-HB_cAg studies were positive with negative HB_sAg. Circulating immune complexes were shown using the C1q-binding assay.

We feel this case satisfies the inclusion criteria of Medsger and Christy.[2] Had we not obtained repeat hepatitis B serologies, a diagnosis of adult Still's disease might have been established by exclusion. But is this diagnosis tenable despite positive hepatitis B serologies?

A case similar to ours has been reported,[3] in which adult Still's disease was described two months after HB_sAg-positive hepatitis, with serologies seven years later showing both anti-HB_sAg and anti-HB_cAg. In view of the variable temporal relationship between hepatitis B infection and related vasculitis,[4] we feel these two cases are compatible with immune complex disease due to hepatitis B.

Many etiologic agents, sharing a common mechanism of disease induction (immune complex formation) are bound, when conjoined with certain constitutional factors, to give rise to identical features. Whether one emphasizes descriptive aspects or putative mechanism of disease is, at our present level of understanding, a matter of personal choice. A diagnostic effort should not stop at the phenomenological level, though we agree with Dr Larson that adult Still's disease is a distinct clinical syndrome. How would he then classify the above two cases?

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Dr Larson Replies

TO THE EDITOR: Drs Lang and Petrozzi report a very interesting case which illustrates one of many problems with the diagnosis of "adult Still's disease." Based on the clinical course and serologic findings, I would classify this patient as having vasculitis and immune complex disease due to hepatitis B. Although elevation of liver enzymes (aspartate aminotransferase and alanine aminotransferase) and acute and chronic hepatitis are seen in patients with adult Still's disease,[1,2] jaundice is not common[1,3,4] except in patients with fulminant hepatic failure or chronic liver disease.[5,6] Most important, although the case does meet the inclusion criteria